Comments for the Record

United States House of Representative

Committee on Ways and Means

Protecting Americans with Pre-Existing Conditions

Tuesday, January 29, 2019 - 10:00am

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Chairman Neal and Ranking Member Brady, thank you for the opportunity to submit these comments for the record to the Committee. As usual, let us preface our remarks in the context of our four part tax reform proposal.

- A Value Added Tax (VAT) to fund domestic military spending and domestic discretionary spending with a rate between 10% and 13%, which makes sure very American pays something.
- Personal income surtaxes on joint and widowed filers with net annual incomes of $100,000 and single filers earning $50,000 per year to fund net interest payments, debt retirement and overseas and strategic military spending and other international spending, with graduated rates between 5% and 25%.
- Employee contributions to Old Age and Survivors Insurance (OASI) with a lower income cap, which allows for lower payment levels to wealthier retirees without making bend points more progressive.
- A VAT-like Net Business Receipts Tax (NBRT), which is essentially a subtraction VAT with additional tax expenditures for family support, health care and the private delivery of governmental services, to fund entitlement spending and replace income tax filing for most people (including people who file without paying), the corporate income tax, business tax filing through individual income taxes and the employer contribution to OASI, all payroll taxes for hospital insurance, disability insurance, unemployment insurance and survivors under age 60.

The key issue for patients is the impact of pre-existing condition reforms on the market for health insurance. If people start dropping insurance until they get sick – which is rational given the repeal of mandates – and Congress does nothing private sector health insurance will be lost. This will require a bailout.

Resorting to catastrophic insurance with health savings accounts (another Republican proposal) would not work as advertised, as health care is not a normal good. While mandates could be replaced with a single payer catastrophic system, it will work.

People will obtain health care upon doctor recommendations, regardless of their ability to pay. Providers will then shoulder the burden of waiting for health savings account balances to accumulate – further encouraging provider consolidation. Existing trends toward provider consolidation will exacerbate these problems, because patients will lack options once they are in a network, giving funders little option other than paying up as demanded.

In what seems counter-intuitive, with the repeal of mandates, should coverage for the poor decline, the best option is to also repeal pre-existing condition reforms. The only way to stop this from happening is to enact a subsidized public option for those with pre-existing conditions. I could end here except that enacting a public option opens wide the issue of funding.

Shifting to more public funding of health care in response to future events is neither good nor bad. Rather, the success of such funding depends upon its adequacy and its impact on the quality of care – with inadequate funding and quality being related.

Ultimately, fixing health care reform will require more funding, probably some kind of employer payroll or net business receipts tax – which would also fund the shortfall in Medicare and Medicaid (and take over most of their public revenue funding). We will now move to an analysis of funding options and their impact on patient care and cost control.

The committee well understands the ins and outs of increasing the payroll tax, so I will confine my remarks to a fuller explanation of Net Business Receipts Taxes (NBRT). Its base is similar to a Value Added Tax (VAT), but not identical.

Unlike a VAT, an NBRT would not be visible on receipts and should not be zero rated at the border – nor should it be applied to imports. While both collect from consumers, the unit of analysis for the NBRT should be the business rather than the transaction. As such, its application should be universal – covering both public companies who currently file business income taxes and private companies who currently file their business expenses on individual returns.

The key difference between the two taxes is that the NBRT would be the vehicle for distributing tax benefits for families, particularly the Child Tax Credit, the Dependent Care Credit and the Health Insurance Exclusion, as well as any recently enacted credits or subsidies under the ACA. In the event the ACA is reformed, any additional subsidies or taxes should be taken against this tax (to pay for a public option or provide for catastrophic care and Health Savings Accounts and/or Flexible Spending Accounts).

The NBRT would replace corporate income taxes and proprietary and pass through taxes and treat all business income the same. It would provide for a public option, the health insurance exclusion or fund single payer insurance.

The NBRT would replace disability insurance, hospital insurance, the corporate income tax, business income taxation through the personal income tax and the mid-range of personal income tax collection.

Collection of this tax would lead to a reduction of gross wages, but not necessarily net wages – although larger families would receive a large wage bump, while wealthier families and childless families would likely receive a somewhat lower net wage due to loss of some tax subsidies and because reductions in income to make up for an increased tax benefit for families will likely be skewed to higher incomes. For this reason, a higher minimum wage is necessary so that lower wage workers are compensated with more than just their child tax benefits.

For further cost savings under an NBRT, allow companies to offer services privately to both employees and retirees in exchange for a substantial tax benefit. Employers who fund catastrophic care would get an even higher benefit, with the proviso that any care so provided be superior to the care available through the public option.

Companies who hire their own doctors and pharmacists and buy their own drugs would get a tax exclusion from single payer (third party insurance would be discouraged), and would negotiate with drug makers for lower prices, although this would leave small firms at a distinct disadvantage and would discourage such practices as franchising and 1099 employment. Still, on the whole, it would decrease cost while not discouraging innovation. Expanding the Uniformed Public Health Service into the Medicare and Medicaid markets (edging out HMOs) would also lead to cost cutting on drugs.

This proposal is probably the most promising way to decrease health care costs from their current upward spiral – as employers who would be financially responsible for this care through taxes would have a real incentive to limit spending in a way that individual taxpayers simply do not have the means or incentive to exercise. While not all employers would participate, those who do would dramatically alter the market. In addition, a kind of beneficiary exchange could be established so that participating employers might trade credits for the funding of former employees who retired elsewhere, so that no one must pay unduly for the medical costs of workers who spent the majority of their careers in the service of other employers.

Employer provided health care will also reverse the trend toward market consolidation among providers. The extent to which firms hire doctors as staff and seek provider relationships with providers of hospital and specialty care is the extent to which the forces of consolidation are overcome by buyers with enough market power to insist on alternatives, with better care among the criteria for provider selection.

Thank you for the opportunity to address the committee. We are, of course, available for direct testimony or to answer questions by members and staff.

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This submission is made on behalf of the American people but by no clients, persons and/or organizations on whose behalf the witness appears.